76-1412

IN THE

Supreme Court of the United States

OCTOBER TERM 1977

No.

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell, Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

Respondents.

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Richard McDonough, Commissioner of Insurance of the State of New Jersey, and James R. Cowan, M.D., Commissioner of Health of the State of New Jersey,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF NEW JERSEY

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On Petition

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Richard McDonough, Commissioner of Insurance of the State of New Jersey, and James R. Cowan, M.D., Commissioner of Health of the State of New Jersey,

---

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

Petitioners, John Borland, etc. et al., pray that a writ of certiorari issue to review the final judgments of the Supreme Court of the State of New Jersey, rendered in the above-captioned matter on January 13, 1977.

CITATIONS TO OPINIONS BELOW

The opinion of the Supreme Court of the State of New Jersey is published, *John Borland, etc., et al. v. Bayonne Hospital* and *John Borland, etc., et al., v. Richard McDonough, Commissioner of Insurance of the State of New Jersey, etc., et al.*, at 72 N.J. 15 (1977). The opinion of the Superior Court Appellate Division in *John Borland, etc., et al. v. Richard McDonough, Commissioner of Insurance of the State of New Jersey, etc., et al.*, is published at 135 N.J. Super. 200 (1975). (See Appendix 82a.) The opinion of the Superior Court Appellate Division in *John Borland, etc., et al. v. Bayonne Hospital, etc., et al.* is published at 136 N.J. Super. 60 (1975). (See Appendix 32a.) The opinion of the Superior Court Chancery Division in *John Borland, etc., et al. v. Bayonne Hospital, etc., et al.* is published at 122 N.J. Super. 387 (1973). (See Appendix 81a.)

JURISDICTION

The final judgment of the Superior Court, Chancery Division in the matter of *John Borland, etc., et al. v. Bayonne Hospital, etc., et al.* was entered on March 9, 1973, on motion for summary judgment in favor of Respondent hospitals and Respondent Hospital Service Plan of New Jersey. On April 13, 1973, Petitioner filed a notice of appeal to the Superior Court of New Jersey, Appellate Division. On October 19, 1973, an order was entered by the Superior Court, Chancery Division transferring the cause of action against Respondents Richard C. McDonough, Commissioner of Insurance and James R. Cowan, Commissioner of Health of the State of New Jersey (in accordance with N.J.C.R. 2:2-3(a)) to the Superior Court Appellate Division.[1] On January 24, 1974, the Superior Court, Appellate Division, remanded the matter of *John Borland, Jr., etc., et al. v. Richard McDonough, etc., et al.* to the Commissioner of Insurance for the purpose of expanding the record, particularly with respect to the method used and the factors considered in establishing the *per diem* rates of reimbursement payable by Respondent Hospital Service Plan of New Jersey to respondent hospitals herein. On July 3, 1975, the Superior Court of New Jersey, Appellate Division, affirmed the final summary judgment of the Superior Court of New Jersey, Chancery Division, 136 N.J. Super 60 (App. Div. 1975). On July 3 ,1975, the Appellate Division rendered final judgment against Petitioners in the companion case of *John Borland, etc., et al. v. Richard McDonough, etc., et al.* Thereafter, notices of appeal to the Supreme Court of the State of New Jersey were timely filed in both cases. On January 13, 1977, the Supreme Court of the State of New Jersey affirmed the final judgments of the courts below in a single opinion. The jurisdiction of this Court is invoked under 28 U.S.C.A. 1257(3), and the Fourteenth Amendment to the Constitution of the United States.

QUESTIONS PRESENTED

I

Whether the constitutional guarantee to equal protection under law is violated where, by statutory design

1. Though bifurcated by reason of the separate avenues to the Appellate Division, the matters were treated as companionate actions in both the Appellate Division and Supreme Court, being argued and determined together; thereafter, the Supreme Court issued one consolidated opinion.

or implementation, indigent care costs incurred by community medical facilities are "passed on" only to cash paying patient members of the community and are not shared by Hospital Service Corporation members of the community.

II

Whether a statutory scheme predicated upon a state legislative goal and objective ". . . to help the *community carry* the social and economic burden created when people are unable to pay for the necessary care rendered in hospitals" is violative of the constitutional guarantee to equal protection under law, where said scheme creates a separate classification of Hospital Service Corporation subscribers (presently comprising approximately 70% of the state's population) and those charged with the administration of said scheme arbitrarily and unreasonably exempt that section of the community from sharing said economic burden.

III

Whether the constitutional guarantee to Due Process of Law is transgressed where, by statutory scheme or implementation, a classification of Hospital Service Corporation subscribers is created, and thereafter, arbitrarily and unreasonably exempted from having to pay its pro rata share of the economic burden of indigent medical care (as well as other costs incurred by hospitals) which must be shared by all other patient members of the community.

IV

Whether the constitutional guarantee to Due Process of Law is violated where, by statutory design and/or implementation, a legislatively created class of Hospital Service Corporation subscribers is needlessly, arbitrarily and discriminately granted a non-functional below-cost basis discount on medical services and facilities, unrelated to a proper governmental purpose, resulting in the de facto subsidization of that class by all cash paying patients.

V

Whether the constitutional guarantee of Due Process of Law is transgressed where claimants asserting the violation of fundamental rights by unreasonable administrative action are, through Summary Judgment, denied the tools of discovery necessary to prove their cause, and thereafter, that Summary Judgment is affirmed upon the basis of a failure to sustain a burden of rebutting a presumption of reasonableness afforded to said administrative action.

VI

Whether the constitutional guarantee of Due Process of Law is violated where those charged by statute with "establishing" Hospital Service Corporation reimbursement rates abrogate their function by allowing the Hospital Service Corporation and hospitals to determine the elements of costs to be considered in the reimbursement formula, resulting in "admittedly inadequate" reimbursement rates, and consequential de facto subsidization of the Hospital Service Corporation program by all cash paying patients.

QUESTIONS AND STATUTES INVOLVED

The constitutional and statutory provisions involved are: Fourteenth Amendment to the Constitution of the United States; Article 1, par. 1 of the New Jersey Constitution of 1947; Article 1, par. 6, 7, 8, 9 of the New Jersey Constitution of 1947; Article 1 §20 of the New Jersey Con-

stitution of 1947; N.J.R.S. 17:48-1 et seq.; N.J.R.S. 26-2H-18; N.J.R.S. 52:14B-1 et seq.; 29 United States Code §147 et seq.; New Jersey Administrative Code 8:31-14.4; New Jersey Court Rules 4:10-2, and 4:46-1 et seq.

STATEMENT OF THE CASE

Petitioners are individual members and trustees of a union welfare fund. Said Petitioners filed suit on behalf of themselves, and also as a class action on behalf of all labor union welfare funds in the State of New Jersey which provide hospital service benefits not funded through Hospital Service Corporations. (Hereinafter "Blue Cross").

The factual basis of Petitioners complaint is that the Blue Cross reimbursement rates agreed to by Blue Cross and the Respondent Hospitals, and approved by the Commissioners of Health and Insurance, by which Blue Cross reimburses hospitals for health care services rendered to Blue Cross subscribers, are lower than the actual cost of such services. In order to make up the deficit, (as admitted by the hospitals) the hospitals then must, and do, charge non-Blue Cross patients higher rates (above the actual costs of services incurred by the non-Blue Cross patients) with the result that payments of these higher rates by such patients (which include Petitioners) actually subsidize the Blue Cross program.

This action was commenced in the Superior Court of New Jersey, Chancery Division, where the case was bifurcated as a result of a successful application by Respondent Commissioners, to transfer said action as against them, to the Appellate Division of the Superior Court inasmuch as the matter in controversy (the computation of the Blue Cross reimbursement rates) was said to be the final determination of an administrative agency and rendering

same appropriate for resolution by the Appellate Court pursuant to N.J.C.R. 2:2-3(a).

Prior thereto, the Respondent hospitals and Blue Cross had successfully moved before the Chancery Court to dismiss the Complaint as against them pursuant to N.J.C.R. 4:6-2, for failure to state a claim upon which relief could be granted (the Chancery Court treated said motion as one for summary judgment, (122 N.J. Super 387, 392 Ch. 1973)).

The Respondent hospitals and Blue Cross conceded that Respondent Commissioners omit from consideration some of the costs necessary to the operation of hospitals when computing the per diem Blue Cross reimbursement rates. One of the costs so omitted is the cost of indigent care. The Respondent hospitals and Blue Cross affirmatively stated in the Appellate Division that, as a result of the costs omitted from consideration, the hospitals incur financial deficits for facilities and services furnished to Blue Cross subscribers, and that as a further result thereof, said hospitals are required to "recapture" the necessary operating costs so omitted by charging Petitioners, and all others similarly situated, at rates in excess of the actual costs incurred by Petitioners, resulting in a de facto subsidization of Blue Cross subscribers.

Petitioners contend that the aforesaid de facto subsidization is effected by the maintenance of an arbitrary, unreasonable and discriminatory bifurcated rate schedule having a differential known to be at least 20% (see 122 N.J. Super. 387, 394 Ch. 1973). Indeed, the Respondent hospitals specifically reserved the right to bring their own action against the Respondent Commissioners by reason of the "admittedly inadequate" Blue Cross reimbursement rates "at an appropriate time." (See *Borland v. Bayonne Hospital*, RAb 17-29 to 32.)

Thoughout these proceedings the Petitioners have contended that the aforesaid de facto subsidization by them and all others similarly situated of the Blue Cross program, as effected through a bifurcated rate schedule having a differential of no less than 20% (Petitioners were precluded from ascertaining the true extent of the differential), is violative of the Fourteenth Amendment to the Constitution of the United States as well as Article I, par. 1, 7, 8, 9, 19 and 20 of the New Jersey Constitution of 1947.

In a contemporaneous action commenced by some of the same Respondent hospitals in the matter *sub judice*, the Superior Court of New Jersey (Appellate Division), determined that the 1975 Blue Cross reimbursement rates promulgated by the Respondent Commissioners are violative of the Administrative Procedure Act (*N.J.S.A.* 52:14b-1 *et seq.*). See *Monmouth Medical Center et al. v. State of New Jersey, et al.*, Docket No. A-2147-74 to A-2151-74 (unreported).

In *Monmouth* the Court ordered the Respondent Commissioners to hold a hearing with respect to the 1975 Hospital Rate Review Program. Said hearing was held June 11, 1975 at which time a representative of Respondent Commissioner of Health testified that until 1974 there were no material regulations approved to implement a state regulatory system for either rate reporting or rate setting (Petitioners' action was commenced in 1972).

Although the Respondent Commissioners, since 1974, allegedly take a more active role in "approving" per diem rembursement rates, the Commissioners to date, still abrogate their most important legislatively delegated power by continuing to permit Respondents Blue Cross and the Hospitals to determine which elements of cost are "inappropriate" for such reimbursement, and therefore, to be excluded from "total operating costs," (by contract) leaving for themselves the mere ministerial function of rate computation based on said elements. Petitioners contend that statutory purpose and design require, at a minimum, a per diem rate of reimbursement paid by Blue Cross to enable the hospitals to "break even" on the costs of providing medical care to Blue Cross subscribers. However, Respondent hospitals stated below that the rate of differential of per diem reimbursement under the bifurcated fee schedules was required as

> "the performance of their fiduciary duty requires hospital trustees to charge rates to the general public which will insure a solvent hospital and a balanced budget (Rab). *As a result the rates hospitals charge others, including plaintiffs, is computed to permit the hospitals to recapture their omitted costs.* The difference in rates is said to approximate twenty (20%) per cent.

On August 15, 1975, Notice of Appeal to the Supreme Court of New Jersey was filed in both cases (Appendix 130a and 131a).

On January 13, 1977, the New Jersey Supreme Court affirmed the judgments of the courts below (Addendum "A" at 18).

REASONS FOR GRANTING WRIT

1. The determination of the courts below that Respondents' administration of a tripartite statutory scheme, resulting in a de facto subsidization of Respondent Blue Cross is constitutionally permissible, does not comport with the precedents of this court. *Reagan v. Farmers Loan & Trust Company*, 154 U.S. 362, 397, 38 L.ed., 1014-1923, 14 S. Ct., 1047 (1894). Respondents concede that there is a differential in the per diem rate of hospital reimbursement paid by Petitioners and that paid by Respondent Blue Cross. The elements of cost which comprise the differential in the bifurcated per diem rates were never fully disclosed to the Court or to Petitioners. Nonetheless, the Chancery Court determined that there was no necessity for a plenary hearing to determine the precise items of cost omitted from consideration by Respondent Commissioners, (see 122 N.J. Super. 387, 395 (Ch. 1973)) since Respondents conceded the existence of a differential in per diem rates approximating twenty (20%) per cent. Nevertheless, Petitioners submit that they were denied Due Process of Law since they were precluded from utilizing the tools of discovery to support their contention that the elements of costs which result in the rate differential were arbitrarily eliminated by Respondent Commissioners in computing the per diem rate of reimbursement. The statutory scheme envisioned by the legislature, requires said Commissioners to consider the total costs necessary to maintain solvency of Respondent hospitals. Therefore, the per diem rate of reimbursement paid by Respondent Blue Cross for services rendered to its subscribers must be equivalent to the cost of medical services rendered to them.

Before the Courts below, Respondent hospitals consistently took the position that the Blue Cross rates set by Respondent Commissioners resulted in operating losses

because those rates did not meet the actual cost of medical services rendered to Blue Cross subscribers. Consequently, Respondent hospitals stated that:

> "the performance of their fiduciary obligations requires hospital trustees to charge rates to the general public which will insure a solvent hospital and balanced budget (*Borland v. Bayonne* Rab 9-24 to 27).

As a result thereof, Respondent hospitals recoup their omitted costs by charging Petitioners, and those similarly situated, with the "loss" they incur on medical services provided to Blue Cross subscribers. However, Respondent Commissioners did not share the view taken by the hospitals. Having successfully bifurcated Petitioners' cause of action by choosing not to join issue with Respondent hospitals and Respondent Blue Cross before the Chancery Court, Respondent Commissioners took the position before the Appellate Division that the per diem rate of reimbursements, which they "approved" for Respondent Blue Cross, fully compensated Respondent hospitals for the actual cost of medical services and facilities furnished Blue Cross subscribers. Although confronted with this highly disputed genuine issue of material fact, which rendered summary judgment inappropriate, both the Appellate Division and the Supreme Court choose to ignore same by perfunctorily affirming the decision of the Chancery Judge.

Petitioners have been precluded by the courts of New Jersey, from determining the precise elements which comprise the per diem rate of reimbursement paid to Respondent hospitals by Respondent Blue Cross, and have been further precluded from determining the elements of the rate differential (which Respondent Commissioners claim is not attributable to the costs of medical services rendered to Blue Cross subscriber patients), resulting in a discriminatory per diem charge paid by Petitioners for identical medical services.

Petitioners' constitutional attack against the Respondent Commissioners, Blue Cross and the hospitals, is not premised upon the admitted differential in the per diem rate of reimbursement per se, but upon the de facto subsidization of cost elements, which are said to be omitted from the per diem rate of reimbursement paid by the Respondent hospitals through per diem rates of reimbursement charged to Petitioners and others similarly situated. When the control attempted to be exercised over private rights is in excess of that which is essential to effectuate the legitimate exercise of the Police Power, constitutionally protected rights to life, liberty, and property are violated. The Equal Protection Clause applies to every exercise of power by the State which affects the individual and his property, *Louisville Gas & Electric Co. v. Coleman*, 277 U.S. 32, 37, 72 L.Ed. 770, 774, 48 S.Ct. 423 (1918). In the case *sub judice*, Petitioners attack the non-functional de facto discount granted to Respondent Blue Cross which results in the appropriation of Petitioners' property.

It has always been a function of this Court to determine whether an act of one party operates to divest another of a vested right, *Skinner v. Oklahoma*, 316 U.S. 535, 541, 86 L.ed. 1655, 1660, 62 S.Ct. 1110 (1942) *Yick Wo v. Hopkins*, 118 U.S. 356, 30 L.ed. 220, 222, 6 S.Ct 1064 (1886) Enshrined in the Fourteenth Amendment is the prophylactic rule forbidding legislation, or the administration of a legislative scheme, by which the property interests of one individual are wrested from him for the benefit of another or for the public.

> "This, as has been often observed, is a government of law, and not a government of men, and it must never be forgotten that under such a form of government, with its constitutional limitations and guarantees, the forms of law and the machinery of government, with all their reach and power, must in their actual workings stop on the hither side of the unnecessary and uncompensated taking or destruction of any private property, legally acquired and legally held. *Reagan v. Farmers Loan & Trust Co.*, 154 U.S. 362, 399, 38 L.Ed. 1014, 1024, 14 S.Ct. 104) (1894).

2. One of the elements of cost admittedly not computed in the per diem rate of reimbursement paid by Respondent Blue Cross, is the cost of providing indigent medical care. Yet, Respondents state that one of the primary governmental goals and objectives of the legislature in enacting the subject statutes was to help the community carry the social and economic burden created by people who are unable to pay for necessary hospital care rendered at Respondent hospital facilities. Certainly, the validity of a legislative classification premised upon a particular governmental objective, must be said to be arbitrary and unreasonable, where a primary objective of the legislative scheme is usurped by the ultra vires administration of the statute, as where the Respondent Commissioners fail to include the cost of indigent care in computing the per diem reimbursement rate of Respondent Blue Cross, whose subscribers comprise approximately seventy (70%) percent of the population. Secondly, the constitutional validity of a state statutory scheme which exempts a specially created legislative class from sharing the burden of indigent costs could not be said to bear a reasonable relationship to the governmental objective sought to be achieved (i.e. broad based community care). The Equal Protection Clause of the Fourteenth Amendment applies to every person within the jurisdiction of a state regardless of accident of accident of birth, sex, or fortune. *Bell v. Maryland*, 378 U.S. 226, 262, 12 L.Ed. 2d 822, 836, 84 S.Ct. 1814 (1964). It acts as a limitation on the exercise of gov-

ernmental power, *Traux v. Corrigan*, 257 U.S. 312, 340, 66 L.ed. 254, 266, 42 S.Ct. 124 (1921). It demands that every person be protected from governmental action which inhibits its equal treatment under law; both in privileges conferred and liabilities imposed. Immunity granted one class from a liability thrust upon all others, absent a reasonable underlying factual basis, is clearly a denial of equal protection. While equal protection acts upon the assumption that government may recognize and act upon factual differences existing among and between persons, it does not sanction "state action," which inhibits equal treatment under like circumstances. The classification of persons or objects must be reasonable, and this reasonableness must have a rational relationship to a valid governmental purpose, *Tigner v. Texas*, 310 U.S. 141, 147, 84 L.ed. 1124, 1128, 60 S.Ct. 879 (1939); *Graham v. Richardson*, 403 U.S. 365, 371, 29 L.ed. 2d 534, 541, 91 S.Ct., 1848 (1971).

As administered by Respondent Commissioners, the statutory scheme here in question thrusts the burden of indigent care upon Petitioners, and others similarly situated while immunizing a governmentally created class from assuming their proportionate share of the economic burden of providing indigent medical care.

> "The Constitution was framed under the diminion of a political philosophy less parochial in range. It was framed upon the theory that the peoples of the several states must sink or swim together, and that in the long run, prosperity and salvation are in *union* and not in *division*. *Baldwin v. G.A.F. Sealing, Inc.*, 294 U.S. 511, 523, 79 L.ed. 1032, 1038, 55 S.Ct. 497 (1921).

3. Petitioners contend that the de facto subsidization of Respondent hospitals, through confiscatory per diem reimbursement rates, interferes with "fundamental rights," requiring the proponents of the statutory scheme to demonstrate the existence of a compelling state interest.

The right to property in a free society is a fundamental right expressly guaranteed by the Fourteenth Amendment. Where fundamental rights are involved the mere showing that a classification is rational will not withstand a constitutional challenge. As presently administered, the statutory scheme in question omits certain cost elements which are necessary to the operation of medical facilities and rendition of health care services, resulting in lost revenues to Respondent hospitals. As a consequence thereof, Respondent hospitals state that they are compelled to charge the general public rates that will insure solvent hospitals. This process of confiscatory reimbursement infringes upon Petitioners' fundamental right to property, as said confiscatory scheme is violative of substantive due process of law.

> "the constitutional prohibition against the deprivation of property without due process of law reflects the high value imbedded in constitutional and political history, that is placed on a person's right to enjoy what is his, free of governmental interference. *Fuentes v. Shavin*, 407 U.S. 67, 81, 32 L.ed 2d 556, 570, 92 S.Ct. 1983 (1972).

4. Petitioners where denied procedural due process in not being allowed to proceed to a plenary hearing, with accompanying discovery by the courts below, so that the true processes by which Respondent Blue Cross reimbursement rates are established could be ascertained.

It is the very essence of Petitioner's position that for purposes of a proper adjudication of their claim, they were entitled to make use of the tools of discovery as set out in the Rules Governing the Courts of New Jersey (N.J.C.R. 4:10-2).

In order to adjudicate Petitioners' constitutional challenge, the lower courts were required to determine the "reasonableness" of those elements excluded from the per diem Blue Cross rates of reimbursement. There can be no doubt as to the Court's power and duty to inquire whether

a schedule of rates is so unreasonable and so unjust, that in practical application, they work to destroy the fundamental right to property guaranteed by the Constitution.

Petitioners submit that in order for the courts below to determine whether the per diem rate structure employed by Respondent hospitals and Blue Cross was discriminatory, it was essential that the elements of the per diem rate be identified and evaluated.

In considering Petitioners constitutional challenge, the lower courts were content to deal solely with the issue of "reasonableness" of the Blue Cross classification vis-a-vis its relationship to a valid governmental purpose, and did not consider the infringement upon Petitioners' fundamental rights which results through the actual administration of the statutory scheme.

Petitioners submit that the lower courts erred in this regard, and in so doing denied Petitioners due process of law. *First*, because the Commissioners had no material regulations for determining the elements of the Blue Cross rate. *Secondly*, because the Commissioners do not determine "total cost," as they limit themselves to the elements found in the Contracting Hospital Agreements which are negotiated by Respondent Blue Cross and the hospitals, thus abrogating and ignoring their statutory duty. *Third*, because a resolution of the constitutional challenge raised by Petitioners to the actual administration of this statutory scheme, demands identification and an evaluation of the excluded items of cost, to determine the appropriateness of their inclusion or exclusion, and ultimately the reasonableness of the confiscatory rate charged to Petitioners, and others similarly situated.

CONCLUSION

For the foregoing reasons, petitioners pray that their petition for an issuance of a writ of Certiorari be granted.

Respectfully submitted,

HAROLD KRIEGER
Counsel for Petitioners

/s/ Harold Krieger
HAROLD KRIEGER

FERRARA & FEINSILVER
Of Counsel on the Petition

ADDENDUM "A"

OPINION OF THE SUPREME COURT OF NEW JERSEY (REPORTED AT 72 N.J. 152)

JOHN BORLAND, JR., J. BARRON LEEDS, LOUIS POLEVOY, IRVING KAPLAN, IRVING LEVY, JOHN NICCOLLAI, AS TRUSTEES OF THE WELFARE FUND OF LOCAL 464, AMALGAMATED MEAT CUTTERS FOOD STORE, EMPLOYEES UNION, AFL-CIO AND HOWARD MARKS, PLAINTIFFS-APPELLANTS, v. BAYONNE HOSPITAL, BERGEN PINES COUNTY HOSPITAL, BETH ISRAEL HOSPITAL, CLARA MAASS MEMORIAL HOSPITAL, ENGLEWOOD HOSPITAL ASSOCIATION, GREATER PATERSON GENERAL HOSPITAL, HACKENSACK HOSPITAL, IRVINGTON GENERAL HOSPITAL, HOLY NAME HOSPITAL, THE HOSPITAL CENTER AT ORANGE, MONMOUTH MEDICAL CENTER, MORRISTOWN MEMORIAL HOSPITAL, MOUNTAINSIDE HOSPITAL, NEWARK BETH ISRAEL MEDICAL CENTER, RIVERDELL HOSPITAL, SADDLE BROOK HOSPITAL, SAINT BARNABAS MEDICAL CENTER, ST. MICHAEL'S MEDICAL CENTER, SOUTH AMBOY MEMORIAL HOSPITAL, ST. JOSEPH'S HOSPITAL, ST. MARY'S HOSPITAL OF HOBOKEN, ST. MARY'S HOSPITAL OF PASSAIC, THE BLUE CROSS-BLUE SHIELD PLAN OF NEW JERSEY, A CORPORATION OF THE STATE OF NEW JERSEY, DEFENDANTS-RESPONDENTS.

JOHN BORLAND, JR., J. BARRON LEEDS, LOUIS POLEVOY, IRVING KAPLAN, IRVING LEVY, JOHN NICCOLLAI, AS TRUSTEES OF THE WELFARE FUND OF LOCAL 464, AMALGAMATED MEAT CUTTERS FOOD STORE, EMPLOYEES UNION, AFL-CIO AND HOWARD MARKS, PLAINTIFFS-APPELLANTS v. RICHARD McDONOUGH, COMMISSIONER OF INSURANCE OF THE STATE OF NEW JERSEY, AND JAMES R. COWAN, M.D., COMMISSIONER OF HEALTH OF THE STATE OF NEW JERSEY, DEFENDANTS-RESPONDENTS.

Argued November 22, 1976—Decided January 13, 1977.

SYNOPSIS

Action was brought to contest allegedly discriminatory hospital rates. The Superior Court, 122 *N. J. Super.* 387, granted summary judgment in favor of defendant hospitals and hospital service corporation, and plaintiffs appealed. The Superior Court, Appellate Division, 136 *N. J. Super.* 60, affirmed, and, 135 *N. J. Super.* 200, affirmed decision of Commissioners of Insurance and Health approving reimbursement rates, and plaintiffs appealed. The Supreme Court, Sullivan, J., held that statutory scheme had sufficient standards to control administrative approval of rates by which hospital service corporation reimbursed hospitals for services rendered its subscribers and that, applying such standards, rational basis had been demonstrated for exclusion of operating expenses in question from computation of rates; and that regulation of reimbursement rates paid by hospital service corporation, which was open for membership to general public, was not only reasonable and in furtherance of state public policy in field of public health care but was consonant with equal protection to all hospital users.

Affirmed.

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1. Constitutional law key 318(2)

Where record as expanded set forth in detail procedure and method of computation by which hospital, service corporation's reimbursement rates were fixed, there was adequate exposure of statutory scheme, and plaintiffs' major contention that reimbursement rates for services rendered corporation's subscribers were lower than hospital rates charged nonsubscribers was conceded, plaintiffs were not denied due process by not being allowed to proceed to plenary hearing to further illuminate processes by which reimbursement rates were established. *N. J. S. A.* 17:48-7, 26:2H-18.

2. Hospitals key 3

Plaintiffs, who were challenging reimbursement rates agreed to by hospital service corporation and hospitals and approved by Commissioners of Health and Insurance for health care services rendered corporation's subscribers, but who failed to show that adjustments by which certain operating expenses of hospitals were excluded in computing reimbursement rates were arbitrary or unreasonable in view of distinction made by statutes and regulations between hospital service corporations open to general public, other health plans, and general public, failed to sustain their burden of rebutting presumption as to reasonableness of administrative action. *N. J. S. A.* 17:48-7, 26:2H-18.

3. Hospital key 3

Statutory scheme under which reasonableness of reimbursement rates for services rendered subscribers of hospital service corporation were approved contained sufficient standards to control administrative approval process and, applying such standards, rational basis was demonstrated for exclusion of operating expenses from computation of

reimbursement rates which either did not involve services rendered subscribers, were items of expenses for which recovery was had from other sources, or were not for services for which corporation was billed at a different rate. *N. J. S. A.* 17:48-7, 9, 26:2H-18.

4. Constitutional law key 240(1)

Hospital key 3

Hospital service corporation, which was open for membership to general public, was sufficiently distinguishable from other health care plans and general public so that its different treatment in connection with computation of reimbursement rates paid hospitals for health care services rendered its subscribers was not arbitrary nor a denial of equal protection even though reimbursement rates fixed were lower than hospital rates charged nonsubscribers, and thus approved of reimbursement rates not only was reasonable and in furtherance of stated policy in field of public health care but was consonant with equal protection to all hospital users. *N. J. S. A.* 17:48-7, 26:2H-18.

Mr. Harold Krieger argued the cause for appellants (*Messrs. Krieger & Chodash*, attorneys).

Mr. Bruce D. Shoulson argued the cause for respondent hospitals and Hospital Service Plans of New Jersey (*Messrs. Lowenstein, Sandler, Brochin, Kohl & Fisher*, attorneys for Newark Beth Israel Medical Center; *Messrs. Winne & Banta*, attorneys for Hackensack Hospital Association; *Messrs. Lebson & Prigoff*, attorneys for Englewood Hospital Association; *Messrs. Johnson, Johnson & Murphy*, attorneys for St. Joseph's Hospital and Medical Center; *Messrs. Schenck, Price, Smith & King*, attorneys for Morristown Memorial Hospital; *Messrs. Booth, Bate, Hagoort, Keith & Harris*, attorneys for Mountainside Hospital; *Messrs. Riker, Danzig, Scherer & Debevoise*, attorneys for The Hospital

Center at Orange and St. Barnabas Medical Center; *Messrs. Wilentz, Goldman & Spitzer*, attorneys for South Amboy Memorial Hospital; *Messers. Pitney, Hardin & Kipp*, attorneys for Hospital Service Plan of New Jersey; *Messrs. McCann and McCann*, attorneys for Saddle Brook General Hospital; *Messrs. Mandak, Roth & Ferrante*, attorneys for St. Mary's Hospital of Passaic; *Messrs. Smith, Kramer & Morrison*, attorneys for Clara Maass Memorial Hospital; *Messrs. Kein, Pollatschek & Iacopino*, attorneys for Irvington General Hospital; *Messrs. Milton, Keane & Brady*, attorneys for St. Michael's Medical Center and St. Mary's Hospital of Hoboken; *Mr. Vincent P. Rigolosi*, Bergen County Counsel, attorney for Bergen Pines County Hospital; *Messrs. Morrison & Griggs*, attorneys for Greater Paterson General Hospital; *Messrs. Clapp & Eisenberg*, attorneys for Riverdell Hospital; *Messrs. Giordano & Halleran*, attorneys for Monmouth Medical Center; *Mr. Elmer Friedbauer*, attorney for Beth Israel Hospital of Passaic; *Messrs. Breslin and Breslin*, attorneys for Holy Name Hospital).

Mr. Wesley S. Caldwell, III, Deputy Attorney General, argued the cause for respondent Commissioners of Insurance and Health of New Jersey (*Mr. William F. Hyland*, Attorney General of New Jersey, attorney).

The opinion of the court was delivered by

SULLIVAN, J. The summary judgment in favor of defendant Hospitals and defendant Hospital Service Plan of New Jersey (hereinafter Blue Cross) is affirmed for the reasons expressed by Judge Fink of the Chancery Division in his opinion reported at 122 *N. J. Super.* 387 (1973), aff'd o. b. 136 *N. J. Super.* 60 (App. Div. 1975) Also, the judgment in favor of the Commissioner of Health of the State of New Jersey and the Commissioner of Insurance of the State of New Jersey is affirmed for the reasons given by the Appellate Division in its opinion reported in *Borland v. McDonough*, 135 *N. J. Super.* 200 (1975). We add the following comments to those opinions.

Plaintiffs appealed to this Court as of right, *R.* 2:2-1(a)(1), alleging a violation of their constitutional rights. Essentially they contend that they were denied procedural due process in not being allowed to proceed to a plenary hearing, with accompanying discovery, in which the true processes by which Blue Cross reimbursement rates to defendant Hospitals are established could be further illuminated. They also claimed a denial of substantive due process in a statutory scheme which, in the absence of a compelling state interest, results in a confiscatory taking of plaintiffs' property. Finally, they argue that the same statutory scheme lacks sufficient standards so as to amount to an unconstitutional delegation of legislative power and, as administered and implemented, is not rationally related to a proper governmental purpose and denies them equal protection under law.

The alleged factual basis for these contentions is that the rates agreed to by Blue Cross and defendant Hospitals, and approved by the Commissioners of Health and Insurance, by which Blue Cross reimburses the hospitals for health care services rendered to Blue Cross subscribers are lower than the actual cost of such services. In order to make up the deficit, the hospitals then must charge non-Blue Cross patients higher rates with the result that payments of these higher rates by such patients (which include plaintiffs) actually subsidize the Blue Cross program.

[1] Plaintiffs' contention that they are entitled to a plenary hearing to develop their factual case is not convincing. The record, as expanded, sets forth in detail the procedure and method of computation by which Blue Cross reimbursement rates are fixed. We have an adequate exposure of the statutory scheme as administered and implemented. See *N. J. S. A.* 17:48-7; *N. J. S. A.* 26:2H-18. Plaintiffs' major factual contention—that the rates fixed by the Commissioners of Health and Insurance by which Blue

Cross reimburses defendant Hospitals for services rendered Blue Cross subscribers are lower than the rates charged plaintiffs and other non-Blue Cross subscribers—is conceded.

[2] Nor are plaintiffs other factual assertions supported by the record to any substantial degree. It appears that the rates by which Blue Cross reimburses the hospitals for services rendered Blue Cross subscribers are based on a method of computation which excludes specified operating expenses of the hospitals. However, the excluded expenses either do not involve services rendered Blue Cross subscribers, are items of expense for which recovery is had from other sources, or are not for services for which Blue Coss is billed at a different rate.[1] The method of calculation does take into–consideration the total expenses of the hospital even though it allows for adjustments in computing the cost of health care service for Blue Cross subscribers not necessarily allowed in the charges to non-subscribers. These adjustments have not shown to be arbitrary or unreasonable insofar as the pertinent statutes and regulations distinguish between hospital service corporations open to the general public, such as Blue Cross, and other health plans restricted in their membership and coverage, and the general public not members of any health plan. There is a strong presumption as to the reasonableness of administrative action. One attacking such action has the burden of rebutting this presumption. Plaintiffs have failed to sustain this burden.

Blue Cross, organized pursuant to *N. J. S. A.* 17:48-1 *et seq.* complements the public health care program of this State. It has established and operates a hospital service plan whereby comprehensive health care services are made

1. For example, the cost of research programs subsidized by special grants is excluded as are the costs of out-patient care since Blue Cross is charged the same rates for such care as is charged to non-subscribers.

available on a non-profit basis. The plan is open to the public (including plaintiffs') as provided by statute. Such an organization and its operation clearly are affected with a public interest.

[3] The declared public policy of this State is that health care services "of the highest quality, of demonstrative need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health." *N. J. S. A.* 26:2H-1. The Legislature, as a means of achieving the goal of "reasonable cost," has empowered the Commissioners of Health and Insurance, after taking into consideration the total costs of the health care facility, to approve the "reasonableness" of the rates by which Blue Cross reimburses hospitals for services rendered its subscribers.[2] This legislative enactment does contain sufficient standards to control the administrative approval process. Applying such standards, a rational basis has been demonstrated for the exclusion of the operating expenses in question.

Plaintiffs also contend that they are denied due process and equal protection by a statutory program which regulates the reimbursement rates paid to hospitals for health care services rendered to Blue Cross subscribers, but makes no provision for regulation of the charges made by hospitals to the general public (including plaintiffs). The result, say plaintiffs, is that non-Blue Cross patients are charged more and pay more for the same health care services.

However, such a differential in hospital rates becomes invidious only if it is shown that the classification from which the rate differential stems does not bear a reasonable relation to a permissible legislative objective. In *David v. Vesta Co.*, 45 N. J. 301, 315 (1965), we held that:

2. The rates which Blue Cross charges its subscribers for health care coverage are also regulated by statute and must be approved by the Commissioner of Insurance. See *N.J.S.A.* 17:48-9. These rates obviously reflect what Blue Cross must pay for health care services rendered its subscribers.

> "• • • The constitutionality of a legislative classification is presumed, and one who assails the classification must carry the burden of showing its arbitrariness. A classification having some reasonable basis is not invalid merely because it is not made with mathematical nicety or because in practice it results in some inequality. And the classification must be upheld if any set of facts can reasonably be conceived to support it. In short, the equal protection clause forbids only invidious discrimination. • • •"

[4] This principle is directly applicable to the situation here presented. We find hospital service corporations open for membership to the general public to be a sufficiently distinguishable category from other health care plans and from that of the general public, not members of any health plan, such that their different treatment in the respect here involved cannot be said to be arbitrary or to deny equal protection. We therefore find the regulation of reimbursement rates paid by a hospital service corporation not only to be reasonable and in furtherance of the stated public policy of this State in the field of public health care, but to be consonant with equal protection to all hospital users. Such regulation is reflected in the rates which Blue Cross is allowed to charge its subscribers to the end that health care protection be made available to the public at a reasonable cost. The judgments applied from are affirmed.

For affirmance—Chief Justice HUGHES, Justices MOUNTAIN, SULLIVAN and PASHMAN and Judge CONFORD—5.

For reversal—None.

ADDENDUM "B"
PENITENT NEW JERSEY STATUTES AND RULES

26:2H-1. Declaration of policy

It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, the State Department of Health, which has been designated as the sole agency in this State for comprehensive health planning under the "Comprehensive Health Planning and Public Health Services Amendments of 1966" (Federal Law 89-749), as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, serving principally as boarding, nursing or maternity homes or other homes for the sheltered care of adult persons or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

26:2H-2. Definitions

The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diag-

nosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic care agency, boarding home or other home for the sheltered care of adult persons and bioanalytical laboratory or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer.

b. "Health care service" means the preadmission, outpatient, in-patient and post-discharge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice or by practitioners of healing solely by prayer. . . .

26:2H-18. Payments by government agency or hospital service corporation; determination of rates

a. No government agency and no hospital service corporation organized under the laws of the State shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him.

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

17:48-1. Definitions

A hospital service corporation is hereby declared to be any corporation organized, without capital stock and not for profit, for the purpose of establishing, maintaining and operating a nonprofit hospital service plan. A hospital service plan is hereby defined as a plan whereby hospital service in health care services are provided by a hospital service corporation or by a hospital or institution health care facility with which the corporation has a contract for such hospital service health care services to persons who become subscribers under contracts with the corporation. Hospital service Health care services provided by a hospital service corporation shall consists of hospital include health care provided (a) through a hospital or institution health care facility which is maintained by a State or any of its political subdivisions; (b) through a hospital or insti-

tution health care facility licensed by the Department of Institutions and Agencies Department of Health; (c) through such other hospitals and institutions, health care facilities as shall have been designated by the Department of Institutions and Agencies Department of Health for hospital care health care servics; (d) through hospitals and institutions, health care facilities located in other states, which are subject to the supervision of such other States provided that such last mentioned hospitals and institutions, health care facilities, if they were located in this State, would be eligible to be licensed or designated by the Department of Institutions and Agencies Department of Health; (e) through nonprofit hospital service plans of other States approved by the Commissioner of Banking and Insurance.

17:48-1.7 Additional powers; contract benefits; disapproval by commissioner; review

Any hospital service corporation organized pursuant to the laws of this State, in addition to other powers conferred upon it, shall be authorized and empowered to include in its contracts benefits not only for hospital services but also benefits for such other related similar health care services and supplies or health care services or supplies other than the services of persons licensed to practice medicine or surgery for any and all employees of an employer and which benefits have been agreed upon by such employer and a union, and which as are approved for such inclusion by the Commissioner of Banking and Insurance. The commissioner may disapprove any contract which makes provision for such health care services and supplies or health care services or supplies if it provides for a type of coverage or contains other provisions which he determines to be unrelated health care services or unjust, unfair, inequitable, misleading, or contrary to law. All determinations of the commissioner under this section shall be subject to review by the Superior Court in a proceeding in lieu of a prerogative writ.

17:48-6. Contracts; certificates; contents

Every individual contract made by a corporation subject to the provisions of this chapter to furnish services to a subscriber shall provide for the furnishing of services for a period of 12 months, and no contract shall be made providing for the inception of such services at a date later than 1 year after the actual date of the making of such contract. Any such contract may provide that it shall be automatically renewed from year to year unless there shall have been at least 30 days prior written notice of termination by

(d) A statement that the contract includes the endorsements thereon and attached papers, if any, and contains the entire contract for services;

(c) A statement that no statement by the subscriber in his application for a contract shall avoid the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract, and that no agent or representative of such corporation, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions;

(f) A statement that if the subscriber defaults in making any payment under the contract, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the contract, but with respect to sickness and injury may cover such sickness as may be first manifested more than 10 days after the date of such acceptance;

(g) A statement of the period of grace which will be allowed the subscriber for making any payment due under the contract. Such period shall be not less than 10 days.

In every such contract made, issued or delivered in this State:

(a) All printed portions shall be plainly printed in type of which the face is not smaller than 10 point;

(b) There shall be a brief description of the contract on its first page and on its filing back in type of which the face is not smaller than 14 point;

(c) The exceptions of the contract shall appear with the same prominence as the benefits to which they apply; and

(d) If the contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the corporation a part of the contract, such portion shall be set forth in full.

52:14B-1. Short title

This act shall be known and may be cited as the "Administrative Procedure Act."
L.1968, c. 410, § 1, eff. Sept. 1, 1969.

52:14B-2. Definitions

As used in this act:

(a) "State agency" or "agency" shall include each of the principal departments in the executive branch of the State Government, and all boards, divisions, commissions, agencies, departments, councils, authorities, offices or officers within any such departments now existing or hereafter established and authorized by statute to make, adopt or promulgate rules or adjudicate contested cases, except the

office of the Governor, the Division of Workmen's Compensation in the Department of Labor and Industry, the Department of Defense, and any boards, divisions, commissions, councils, agencies, departments, authorities, offices or officers therein, and all agencies the primary responsibility of which is the management or operation of a State educational, medical, mental, rehabilitative, custodial, penal or correctional institution or program, insofar as the acts of such agency relate to the internal affairs of such institution or program.

(b) "Contested case" means a proceeding, including any licensing proceeding, in which the legal rights, duties, obligations, privileges, benefits or other legal relations of specific parties are required by constitutional right or by statute to be determined by an agency by decisions, determinations, or orders, addressed to them or disposing of their interests, after opportunity for an agency hearing.

(c) "Administrative adjudication" or "adjudication" includes any and every final determination, decision or order made or rendered in any contested case.

(d) "The head of the agency" means and includes the individual or group of individuals constituting the highest authority within any agency authorized or required by law to render an adjudication in a contested case.

(e) "Administrative rule" or "rule," when not otherwise modified, means each agency statement of general applicability and continuing effect that implements or interprets law or policy, or describes the organization, procedure or practice requirements of any agency. The term includes the amendment or repeal of any rule, but does not include: (1) statements concerning the internal management or discipline of any agency; (2) intra-agency and inter-agency statements; and (3) agency decisions and findings in contested cases.

(f) "License" includes the whole or part of any agency license, permit, certificate, approval, chapter, registration or other form of permission required by law.

(g) "Secretary" means the Secretary of State.

(h) "Director" shall mean the Director of the Division of Administrative Procedure, unless otherwise indicated by context.

52:14B-3. Additional rule-making requirements

In addition to other rule-making requirements imposed by law, each agency shall:

(1) adopt as a rule a description of its organization, stating the general course and method of its operations and the methods whereby the public may obtain information or make submissions or requests;

(2) adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available, including a description of all forms and instructions used by the agency;

(3) make available for public inspection all final orders, decisions, and opinions, in accordance with the provisions of chapter 73 of the laws of 1963 as amended and supplemented (c. 47:1A-1 et seq.)

52:14B-4. Notice and hearing

(a) Prior to the adoption, amendment, or repeal of any rule, except as may be otherwise provided the agency shall:

(1) Give at least 20 days' notice of its intended action. The notice shall include a statement of either the terms or substance of the intended action or a description of the subjects and issues involved, and

the time when, the place where, and the manner in which interested persons may present their views thereon. The notice shall be mailed to all persons who have made timely request of the agency for advance notice of its rule-making proceedings and in addition to other public notice required by law shall be published in the New Jersey Register;

(2) Afford all interested persons reasonable opportunity to submit data, views, or arguments, orally or in writing. The agency shall consider fully all written and oral submissions respecting the proposed rule.

(b) A rule prescribing the organization or procedure of an agency may be adopted at any time without prior notice or hearing. Such rule shall be effective upon filing in accordance with section 5 of this act or upon any later date specified by the agency.

(c) If an agency finds that an imminent peril to the public health, safety, or welfare requires adoption of a rule upon fewer than 20 days' notice and states in writing its reasons for that finding, it may proceed without prior notice or hearing or upon any abbreviated notice and hearing that it finds practicable, to adopt the rule.

(d) No rule hereafter adopted is valid unless adopted in substantial compliance with this section. A proceeding to contest any rule on the ground of noncompliance with the procedural requirements of this section must be commenced within 1 year from the effective date of the rule.

52:14B-8. Declaratory rulings

Subject to the provisions of section 4(b) and 4(e) of chapter 20, laws of 1944, as amended and supplemented (C. 52:17A-4b and 4e), an agency upon the request of any

interested person may in its discretion make a declaratory ruling with respect to the applicability to any person, property or state of facts of any statute or rule enforced or administered by that agency. A declaratory ruling shall bind the agency and all parties to the proceedings on the state of facts alleged. Full opportunity for hearing shall be afforded to the interested parties. Such ruling shall be deemed a final decision or action subject to review in the Appellate Division of the Superior Court. Nothing herein shall affect the right or practice of every agency in its sole discretion to render advisory opinions.

52:14B-9. Notice and hearing in contested cases

(a) In a contested case, all parties shall be afforded an opportunity for hearing after reasonable notice.

(b) The notice shall include in addition to such other information as may be deemed appropriate:

(1) A statement of the time, place, and nature of the hearing;

(2) A statement of the legal authority and jurisdiction under which the hearing is to be held;

(3) A reference to the particular sections of the statutes and rules involved;

(4) A short and plain statement of the matters asserted. If the agency or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter upon application a more definite and detailed statement shall be furnished.

(c) Opportunity shall be afforded all parties to respond, appear and present evidence and argument on all issues involved.

(d) Unless precluded by law, informal disposition may be made of any contested case by stipulation, agreed settlement, or consent order.

(e) Oral proceedings or any part thereof shall be transcribed on request of any party at the expense of such party.

(f) Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

(g) Unless otherwise provided by any law, agencies may place on any party the responsibility of requesting a hearing if the agency notifies him in writing of his right to a hearing and of his responsibility to request the hearing.

NEW JERSEY COURT RULES

2:2-3. Appeals to the Appellate Division from Final Judgments, Decisions, Actions and from Rules

(a) As of Right. Except as otherwise provided by R. 2:2-1(a) (3) (final judgments, appealable directly to the Supreme Court), appeals may be taken to the Appellate Division as of right (1) from final judgments of the Superior Court trial divisions, the county court or the judges thereof sitting as statutory agents; the juvenile and domestic relations courts except in bastardy and paternity proceedings; the county district courts in civil actions except bastardy and paternity proceedings; and in summary contempt proceedings in all trial courts except municipal courts; (2) to review final decisions or actions of any state administrative agency or officer except those governed by R. 4:74-8 (Wage Collection Section appeals), or to review the validity of any rule promulgated by such agency or officer; (3) in such cases as are provided by law. Unless the interest of justice requires otherwise, review pursuant to R. 2:2-3(a) (2) shall not be maintainable so long as there is available a right of review before any administrative agency or officer.

(b) Time: Effect of Certain Motions. Unless the court fixes a different time period, the time periods prescribed in paragraph (a) of this rule are altered by the filing and service of a motion under R. 4:6 or for summary judgment under R. 4:46 or R. 4:69-2 as follows: (1) if the motion is denied in whole or part or its disposition postponed until trial, the responsive pleading shall be served within 10 days after notice of the court's action; (2) if a motion for a more definite statement is granted, the responsive pleadings shall be served within 10 days after the service of such statement. If notice is given a

nonresident party demanding security for costs and the nonresident gives notice of the filing of the bond or the making of the deposit, the party making the demand shall then have the same time to plead as may have remained at the time of the service of the notice demanding the security.

4:46-1. Time of Motion

A party seeking any affirmative relief, including a declaratory judgment may, at any time after the expiration of 20 days from the service of his pleading claiming such relief, or after service of a motion for summary judgment by the adverse party, move for a summary judgment or order in his favor upon all or any part thereof or as to any defense. A party against whom a claim for such affirmative relief is asserted may move at any time for a summary judgment or order in his favor as to all or any part thereof.

4:46-2. Motion and Proceedings Thereon

The motion for summary judgment shall be served with briefs and with or without supporting affidavits. The judgment or order sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact challenged and that the moving party is entitled to a judgment or order as a matter of law. The court shall find the facts and state its conclusions in accordance with R. 1:7-4. A summary judgment or order, interlocutory in character may be rendered on any issue in the action (including the issue of liability) although there is a genuine factual dispute as to any other issue (including any issue as to the amount of damages). Subject to the provisions of R. 4:42-2 (judgment upon multiple claims), a summary judgment final in character may be rendered in respect of any portion of the damages claimed.

4:46-3. Case Not Fully Adjudicated on Motion

If on motion under this rule judgment is not rendered upon the whole action or for all the relief asked and a trial is necessary, the court at the hearing of the motion, by examining the pleadings and the evidence before it and by interrogating counsel, shall, if practicable, ascertain what material facts, including facts as to the amount of damages, exist without substantial controversy and shall thereupon make an order specifying those facts and directing such further proceedings in the action as are appropriate. Upon trial of the action the facts so specified shall be deemed established.

4:46-4. Leave to Proceed Upon Terms

Leave to proceed may be given unconditionally, or upon such terms as to giving security, or time or mode of trial, or otherwise, as is deemed just.

4:46-5. Affidavits

(a) Specific Facts Required of Adverse Party unless Affidavits are Unavailable. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of his pleading, but his response by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate, shall be entered against him, unless it appears from the affidavits submitted by him that he cannot, for reasons therein stated, present by affidavit facts essential to justify his opposition, in which case the court may deny the motion, may order a continuance to permit additional affidavits to be obtained, depositions to be taken or discovery to be had, or may make such other order as may be appropriate.

(b) Affidavits Made in Bad Faith. If the court is satisfied, at any time, that any of the affidavits submitted pursuant to this rule are presented in bad faith or solely for the purpose of delay, the court shall forthwith order the party employing them to pay to court shall forthwith order the party employing them to pay to the other party the amount of the reasonable expenses which the filing of the affidavits caused him to incur, including reasonable attorney's fees, and any offending party or attorney may be adjudged guilty of contempt.